Chemical Dependency Professional (CDP) Certification Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Chemical Dependency Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct forms required.

☐ **Application Fee**. This fee is **non-refundable.** You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted as exam, endorsement, grandfathered or similar with type, date, grantor, and if the credential is current. Attach additional completed pages if you need more space.

☐ **4. Education:**
List in date order, most recent to later, your postsecondary education. Attach additional completed pages if you need more space.

☐ **5. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

☐ **6. Examination Data:**
If you passed the National Association of Alcohol and Drug Abuse Counselors (NAADAC) or the International Certification Reciprocity Consortium (ICRC) exam, verification must be sent directly to this office by NAADAC or ICRC. It can be sent from the state where you took and passed the exam.

What does NAADAC Certification or ICRC International certification do for me?
A person certified with NAADAC or internationally certified with ICRC has met all of the experience requirements. Certification verifies the 45 quarter or 30 semester hours of topics listed in WAC 246-811-030(2)(a) through (w). Certification confirms your experience. Verification must be sent directly from NAADAC or ICRC.

You must still confirm the additional 45 quarter or 30 semester in courses covering the subject content described in WAC 246-811-030(1). Official transcripts are required.

☐ **7. Course Topics Identification:**
At least 45 quarter or 30 semester credits must be in courses specific to alcohol and drug addicted individuals. Courses must address the topics listed in WAC 246-811-030(2), (a) through (w). List the course topic and the course number. One course may be used for more than one topic.

☐ **8. Applicant’s Attestation:**
You must sign and date this for us to process the application.

☐ **Application Deadlines for Exam Information**

- 90 Days Prior to the Exam

Your complete application form and application fee for certification must be postmarked no later than 90 days prior to the exam. Exam dates can be viewed at our **Web site**:

- 60 Days Prior to the Exam

Verification forms, transcripts, and any other supporting documentation required to complete your application file. This includes special accommodation requests. They are considered supporting documents and must be postmarked 60 days prior to the exam date. If the supporting documents are not received, your application will be forwarded to the next exam cycle. You will receive a letter confirming the exam approval and registration form.

National Association of Alcohol and Drug Abuse Counselors (NAADAC) level 1 or higher or the International Certification Reciprocity Consortium (ICRC) exam meet the requirements for certification. For information about the exam contact NAADAC or ICRC. Within six to eight weeks of taking the exam, candidates will receive a notification via U.S. mail from the Department of Health regarding their state certification status.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0207060000

Chemical Dependency Professional Certification Application

Please type or print clearly. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address			
City	State	Zip	County
Country			

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip	County
Country			

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License #_____ Issue Date_____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Other License, Certification, or Registration (Include Washington State)

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year issued	Number

4. Education

List in date order all your post-secondary school(s) attended, major, month and year the degree was granted. Request your transcripts from the post-secondary school(s) you attended, and have the school send transcripts **directly** to the Department of Health.

School	Degree	Major	Degree Granted (mm/yyyy)

5. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

- ☐ School curriculum
- ☐ Employer/Other

Applicant's Initials	Date

6. Examination Data

Have you taken and passed the:

NAADAC ☐ Yes ☐ No Year? _____ ICRC ☐ Yes ☐ No Year? _____

Are you **nationally** certified by **NAADAC**? ☐ Yes ☐ No

Are you **internationally** certified by **ICRC**? ☐ Yes ☐ No

If yes, verification must be sent directly to the Department of Health, Chemical Dependency Professional Program, from NAADAC, ICRC or the state in which you took and passed the examination.

7. Course Topics Identification

Minimum Requirements: **WAC 246-811-030**, an associates degree in human services or related field from an approved school, or successful completion of 90 quarter or 60 semester college credits in courses from an approved school. At least 45 quarter or 30 semester credits must be in courses specific to alcohol and drug addicted individuals and must include the topics listed below. Identify the course you took and the associated course number. One course may be used for more than one topic area.

Topic Area	Course Title	Course #	Date
a. Understanding addiction.			
b. Pharmacological actions of alcohol and other drugs.			
c. Substance abuse and addiction treatment methods.			
d. Understanding addiction placement, continuing care, and discharge criteria, including ASAM criteria.			
e. Cultural diversity including people with disabilities and its implication for treatment.			
f. Chemical dependency clinical evaluation (screening and referral to include comorbidity).			
g. HIV/AIDS brief risk intervention for the chemically dependent.			
h. Chemical dependency treatment planning.			
i. Referral and use of community resources.			
j. Service coordination (implementing the treatment plan, consulting, continuing assessment and treatment planning).			
k. Individual counseling.			
l. Group counseling.			
m. Chemical dependency counseling for families, couples, and significant others.			
n. Client, family and community education.			
o. Developmental psychology.			
p. Psychopathology/abnormal psychology.			
q. Documentation, to include, screening, intake, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data.			
r. Chemical dependency confidentiality.			
s. Professional and ethical responsibilities.			
t. Relapse prevention.			
u. Adolescent chemical dependency assessment and treatment.			
v. Chemical dependency case management.			
w. Chemical dependency rules and regulations			

8. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

Washington State Department of Health
Chemical Dependency Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Registration / Certification / License
Out of State Verification

Applicant Name: _____ Birth date: _____

I,_____ ,Secretary of_____ ,

hereby certify that _____

was granted state: ☐ Registration ☐ Certificate ☐ License

Number:_____to practice _____

in the State of _____ on the_____ day of _____ , 20_____ .

On the basis of: ☐ Successfully passing the required examination. ☐ Grandfathered

Did the applicant take and pass the NAADAC exam? ☐ Yes ☐ No Score ____ Date _____.
Did the applicant take and pass the ICRC level II or higher exam? ☐ Yes ☐ No Score ____ Date _____.

Required Education?_____

Required Experience?_____

Status of License: ☐ Current Expiration Date: _____ ☐ Expired Date _____

Legal/Disciplinary Action: ☐ Yes ☐ No If Yes, explain: _____

_____

_____

_____

_____

Seal

Acting In Behalf of the:

Official Name of Board _____

Phone _____

Secretary_____

Date Certification Prepared_____

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Washington State Department of Health
Chemical Dependency Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Verification of Chemical Dependency Professional Supervision and Experience

Note: Use one form per supervisor for each time frame worked.
Print or Type Clearly:

Applicant			
Name: Last	First	Middle	Birth date (mm/dd/yyyy)
Address:			
City:	State:	Zip Code:	
Phone (enter 10 digit #)	Business phone (enter 10 digit #)		

Direct Supervisor			
The above applicant requires verification of supervised experience for certification as a chemical dependency professional. Please complete the following.			
Supervisor Name: Last	First	Middle	Credential #
Street Address		Phone (enter 10 digit #)	
City	State	Zip Code	

Supervised Experience **(WAC 246-811-045)**

From (mm/dd/yyyy): To (mm/dd/yyyy):

Competencies gained during the experience **(WAC 246-811-047)**. The first fifty hours of any face-to-face client contact must be under the direct observation of an approved supervisor **(WAC 246-811-049)**.

I attest that the first fifty hours of face-to-face client contact was under my direct observation or I assigned a chemical dependency professional to have direct observation in my stead.

Signature of Supervisor Date

Direct Supervisor	**# of Hours**
Face-to-face clinical evaluation (100 hours required)	
Other clinical evaluation (100 hours required)	
Face-to face counseling to include: Individual counseling, group counseling, and counseling family, couples, and significant others (600 hours required)	
Discussions of professional and ethical responsibilities (50 hours required)	
Transdisciplinary foundations: Understanding addiction treatment knowledge, application to practice, professional readiness, referral, service coordination, client, family, and community education. Documentation to include screening, intake assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other client related data. **AA degree = 1,650 hours required in transdisciplinary foundations** **BA degree = 1,150 hours required in transdisciplinary foundations** **MA degree = 650 hours required in transdisciplinary foundations** **Advanced Registered Nurse Practitioners, Licensed Counselors and Psychologists = 150 hours required in transdisciplinary foundations**	
Total Number of Supervised Experience Hours	

Washington State Department of Health
Chemical Dependency Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Chemical Dependency Professional Statement of Qualifications

Note to Supervisor:

To be considered an **appropriate supervisor,** your qualifications must either meet or exceed the requirements of a certified chemical dependency professional in the state of Washington. You must be eligible to take the examination required for certification and have at least four-thousand hours of experience in a state approved chemical dependency treatment agency. The four thousand hours are in addition to the supervised experience hours needed to be eligible to become a chemical dependency professional. Twenty-eight clock hours of recognized supervised training may be substituted for one thousand hours of experience. You are not a blood or legal relative, significant other, cohabitant of the supervisee, or someone who has acted as the person supervised's primary counselor.

Do not sign this form verifying applicant's hours unless you meet the criteria and can provide documentation if called upon to do so.

My qualifications include:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify the above information is, to the best of my knowledge, accurate and complete. I understand the department may request additional information, if needed, to evaluate the application of the individual named on this document. I also attest that I meet or exceed the educational and supervision requirements for certification (as required by **WAC 246-811-049**).

_____ _____

Signature of Supervisor Date

Please return this form directly to the address above.

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Chemical Dependency Professional, RCW ..... RCW 18.205

Chemical Dependency Professional, WAC ..... WAC 246-811

OnLine

AIDS Training Resources ..... Reference Page

Chemical Dependency Professional Program..... Web Page

ListServ

To receive emails regarding important chemical dependency Professional Information, please join our interested parties list at: ..... Listserv